PLEASE TAKE FURTHER NOTICE that these are continuing demands and supplemental responses up to the time the case is placed on the trial calendar are required.

PLEASE TAKE FURTHER NOTICE that in the event of your failure to furnish such a bill of particulars within the said period of thirty (30) days, a motion will be made for an order precluding you from giving any evidence at the time of trial of the above items from which particulars have not been delivered in accordance with said demand.

Dated: White Plains, New York
September 26, 2007

Yours, etc.,

RENDE, RYAN & DOWNES, LLP.

By: _____
CHRISTOPHER J. WHITTON
Attorneys for Defendant
CIRCUIT CITY STORES, INC.
202 Mamaroneck Avenue
White Plains, New York 10601
(914) 681-0444

TO: SHAEVITZ & SHAEVITZ, ESQS.
Attorneys for Plaintiff
148-55 Hillside Avenue
Jamaica, New York 11435
Attention: Stuart Sears, Esq.
718-291-3400

EXHIBIT "C"

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

----------X

ANNA THOMAS,

Plaintiff(s),

NOTICE OF CERTIFICATION

-against-

Index No.: 20767/07

CIRCUIT CITY STORES, INC., and "JOHN DOES", said named being fictitious and is intended to represent the unknown employees of the defendant.

Defendant(s).

----------X

COUNSELORS:

The following papers accompany this Certification page:

NOTICE OF AVAILABILITY:

AUTHORIZATIONS:
-Elmhurst Hospital
-St. Luke's Roosevelt Hospital
-New York Othopedic Surgery and Rehabilitation
-Lenox Hill Radiology & Medical Imaging Associates, P.C.
-Sedgwick Claims Services (collateral source)

-PLAINTIFF'S VERIFIED BILL OF PARTICULARS;

-PLAINTIFF'S RESPONSE TO DEFENDANTS' COMBINED DEMANDS;

-PLAINTIFF'S DEMAND FOR VERIFIED BILL OF PARTICULARS;

-PLAINTIFF'S NOTICE FOR DISCOVERY & INSPECTION WITH DEMAND PURSUANT TO CPLR (d)(i)(1);

-NOTICE OF DEPOSITION UPON ORAL EXAMINATION.

Dated: Jamaica, New York
November 1, 2007

Yours, etc.,

SHAEVITZ & SHAEVITZ, ESQS.
By: Stuart Sears, Esq.
148-55 Hillside Avenue
Jamaica, New York 11418
(718) 291-3400

TO: ***RENDE, RYAN & DOWNES, LLP***
Attorneys for Defendant(s)
CIRCUIT CITY STORES, INC.
202 Mamaroneck Avenue
White Plains, New York 10601
(914) 681-0444
File No.: S-125-CW

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANNA THOMAS	05/26/37	053-46-3979
Patient Address: 99-10 60th Avenue, Apt. 5J, Corona, New York 11368		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

Duplicate copies of all records provided pursuant to this authorization are to be provided to patient's attorney Shaevitz & Shaevitz, 148-55 Hillside Avenue, Jamaica, N.Y. 11435. If there will be a charge, please contact us at 718-291-3400.

7. Name and address of health provider or entity to release this information:
ELMHURST HOSPITAL, 79-01 Broadway, Elmhurst, New York

8. Name and address of person(s) or category of person to whom this information will be sent:
RENDE, RYAN & DOWNES, LLP, 202 Mamaroneck Avenue, White Plains, New York 10601

9(a). Specific information to be released:

- ☒ Medical Record from (insert date) 12/28/06 to (insert date) 12/28/06
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	12/08
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 11/20/07
Signature of patient or representative authorized by law.
MARK SHAEVITZ - Representative

STUART L. SEARS
NOTARY PUBLIC, State of New York
No. 02SE6[illegible]
Qualified in Queens County
Commission Expires September 11, 20[illegible]

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

LIMITED POWER OF ATTORNEY

I, Anna Thomas
residing at 99-10 60th Avenue, Corona N-Y 11368

do hereby appoint my attorneys, SHAEVITZ & SHAEVITZ, ESQ. or their designated agents, employees or legal associates severally, as my attorneys-in-fact to act in my name place and stead, pursuant to Section 18 of the Public Health Law of the State of New York, in any way which I myself could do if I were personally present with respect to release of my medical records from any named health care provider or entity to whom a HIPAA authorization is presented in my name, which directs release of the records indicated on the HIPAA authorization to any third person, including any named category of person or entity; this power includes signing my name to such HIPAA authorizations for release of my health information. This power shall remain in effect until revoked.

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof, I have hereunto signed my named on this 31 day of May 2007

x Anna Thomas

State of New York
County of Queens

On this day of May 31 2007, before me personally came to me know, known to me to be the individual desribed in, and who executed the foregoing instrument and he acknowledged to me that he executed the same.

MARK A SHAEVITZ
Notary Public, State of New York
No 02SH5032300
Qualified in Nassau County
Commission Expires August 22 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANNA THOMAS	05/26/37	053-46-3979

Patient Address: 99-10 60th Avenue, Apt. 5J, Corona, New York 11368

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

Duplicate copies of all records provided pursuant to this authorization are to be provided to patient's attorney Shaevitz & Shaevitz, 148-55 Hillside Avenue, Jamaica, N.Y. 11435. If there will be a charge, please contact us at 718-291-3400.

7. Name and address of health provider or entity to release this information:
ST. LUKE'S ROOSEVELT HOSPITAL, 1111 Amsterdam Avenue, New York New York 10025

8. Name and address of person(s) or category of person to whom this information will be sent:
RENDE, RYAN & DOWNES, LLP, 202 Mamaroneck Avenue, White Plains, New York 10601

9(a). Specific information to be released:

☒ Medical Record from (insert date) 12/29/06 to (insert date) 12/29/06

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	12/08
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: 11/20/07

Signature of patient or representative authorized by law.

MARK SHAEVITZ - Representative

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify a person as having HIV symptoms or infection and information regarding a person's contacts.

LIMITED POWER OF ATTORNEY

I, Anna Thomas
residing at 99-10 60th Avenue, Corona N-Y 11368

do hereby appoint my attorneys, SHAEVITZ & SHAEVITZ, ESQ. or their designated agents, employees or legal associates severally, as my attorneys-in-fact to act in my name place and stead, pursuant to Section 18 of the Public Health Law of the State of New York, in any way which I myself could do if I were personally present with respect to release of my medical records from any named health care provider or entity to whom a HIPAA authorization is presented in my name, which directs release of the records indicated on the HIPAA authorization to any third person, including any named category of person or entity; this power includes signing my name to such HIPAA authorizations for release of my health information. This power shall remain in effect until revoked.

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof, I have hereunto signed my named on this 31 day of May 2007

xAnna Thomas

State of New York
County of Queens

On this day of May 31 2007, before me personally came to me know, known to me to be the individual desribed in, and who executed the foregoing instrument and he acknowledged to me that he executed the same.

MARK A SHAEVITZ
Notary Public, State of New York
No 02SH5032300
Qualified in Nassau County
Commission Expires August 22 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANNA THOMAS	05/26/37	053-46-3979

Patient Address: 99-10 60th Avenue, Apt. 5J, Corona, New York 11368

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

Duplicate copies of all records provided pursuant to this authorization are to be provided to patient's attorney Shaevitz & Shaevitz, 148-55 Hillside Avenue, Jamaica, N.Y. 11435. If there will be a charge, please contact us at 718-291-3400.

7. Name and address of health provider or entity to release this information:
NEW YORK ORTHOPAEDIC SURGERY & REHABILITATION, 38-25 Astoria Blvd., Astoria, New York 11103

8. Name and address of person(s) or category of person to whom this information will be sent:
RENDE, RYAN & DOWNES, LLP, 202 Mamaroneck Avenue, White Plains, New York 10601

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

XX Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ ***HIV*-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	12/08
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 11/20/07

Signature of patient or representative authorized by law.

MARK SHAEVITZ - Representative

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

LIMITED POWER OF ATTORNEY

I, Anna Thomas
residing at 99-10 60th Avenue, Corona N-Y 11368

do hereby appoint my attorneys, SHAEVITZ & SHAEVITZ, ESQ. or their designated agents, employees or legal associates severally, as my attorneys-in-fact to act in my name place and stead, pursuant to Section 18 of the Public Health Law of the State of New York, in any way which I myself could do if I were personally present with respect to release of my medical records from any named health care provider or entity to whom a HIPAA authorization is presented in my name, which directs release of the records indicated on the HIPAA authorization to any third person, including any named category of person or entity; this power includes signing my name to such HIPAA authorizations for release of my health information. This power shall remain in effect until revoked.

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof, I have hereunto signed my named on this 31 day of May 2007

x Anna Thomas

State of New York
County of Queens

On this day of May 31 2007, before me personally came to me know, known to me to be the individual desribed in, and who executed the foregoing instrument and he acknowledged to me that he executed the same.

MARK A SHAEVITZ
Notary Public, State of New York
No 02SH5032300
Qualified in Nassau County
Commission Expires August 22 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANNA THOMAS	05/26/37	053-46-3979

Patient Address: 99-10 60th Avenue, Apt. 5J, Corona, New York 11368

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

Duplicate copies of all records provided pursuant to this authorization are to be provided to patient's attorney Shaevitz & Shaevitz, 148-55 Hillside Avenue, Jamaica, N.Y. 11435. If there will be a charge, please contact us at 718-291-3400.

7. Name and address of health provider or entity to release this information:
LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOC., 61 East 77th Street, New York, New York 10021

8. Name and address of person(s) or category of person to whom this information will be sent:
RENDE, RYAN & DOWNES, LLP, 202 Mamaroneck Avenue, White Plains, New York 10601

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☒ Other: MRI films and reports

Include: (*Indicate by Initialing*)

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	12/08
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: 11/20/07

Signature of patient or representative authorized by law.

MARK SHAEVITZ - Representative

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

STUART L. SEAPS
NOTARY PUBLIC, State of New York
No. 02SE5049703
Qualified in Queens County
Commission Expires September 11, 09

LIMITED POWER OF ATTORNEY

I, Anna Thomas
residing at 99-10 60th Avenue, Corona N-Y 11368

do hereby appoint my attorneys, SHAEVITZ & SHAEVITZ, ESQ. or their designated agents, employees or legal associates severally, as my attorneys-in-fact to act in my name place and stead, pursuant to Section 18 of the Public Health Law of the State of New York, in any way which I myself could do if I were personally present with respect to release of my medical records from any named health care provider or entity to whom a HIPAA authorization is presented in my name, which directs release of the records indicated on the HIPAA authorization to any third person, including any named category of person or entity; this power includes signing my name to such HIPAA authorizations for release of my health information. This power shall remain in effect until revoked.

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof, I have hereunto signed my named on this 31 day of May 2007

x Anna Thomas

State of New York
County of Queens

On this day of May 31 2007, before me personally came to me know, known to me to be the individual desribed in, and who executed the foregoing instrument and he acknowledged to me that he executed the same.

MARK A SHAEVITZ
Notary Public, State of New York
No 02SH5032300
Qualified in Nassau County
Commission Expires August 22 2010

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANNA THOMAS	05/26/37	053-46-3979
Patient Address: 99-10 60th Avenue, Apt. 5J, Corona, New York 11368		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

Duplicate copies of all records provided pursuant to this authorization are to be provided to patient's attorney Shaevitz & Shaevitz, 148-55 Hillside Avenue, Jamaica, N.Y. 11435. If there will be a charge, please contact us at 718-291-3400.

7. Name and address of health provider or entity to release this information:
SEDGWICK CLAIMS SERVICES, P.O. Box 171816, Memphis, TN 38187, Claim No.: A767046480

8. Name and address of person(s) or category of person to whom this information will be sent:
RENDE, RYAN & DOWNES, LLP, 202 Mamaroneck Avenue, White Plains, New York 10601

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☒ Other: collateral source

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	12/08
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 11/20/07
Signature of patient or representative authorized by law.
MARK SHAEVITZ - Representative

STUART L. SEARS
NOTARY PUBLIC, State of New York

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

04

LIMITED POWER OF ATTORNEY

I, Anna Thomas
residing at 99-10 60th Avenue, Corona N-Y 11368

do hereby appoint my attorneys, SHAEVITZ & SHAEVITZ, ESQ. or their designated agents, employees or legal associates severally, as my attorneys-in-fact to act in my name place and stead, pursuant to Section 18 of the Public Health Law of the State of New York, in any way which I myself could do if I were personally present with respect to release of my medical records from any named health care provider or entity to whom a HIPAA authorization is presented in my name, which directs release of the records indicated on the HIPAA authorization to any third person, including any named category of person or entity; this power includes signing my name to such HIPAA authorizations for release of my health information. This power shall remain in effect until revoked.

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof, I have hereunto signed my named on this 31 day of May 2007

x Anna Thomas

State of New York
County of Queens

On this day of May 31 2007, before me personally came

to me know, known to me to be the individual desribed in, and who executed the foregoing instrument and he acknowledged to me that he executed the same.

MARK A SHAEVITZ
Notary Public, State of New York
No 02SH5032300
Qualified in Nassau County
Commission Expires August 22 2010

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

----------X

ANNA THOMAS,

Plaintiff(s),

VERIFIED BILL OF PARTICULARS

-against-

Index No.: 20767/07

CIRCUIT CITY STORES, INC., and "JOHN DOES", said named being fictitious and is intended to represent the unknown employees of the defendant.

Defendant(s).

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Plaintiff, as and for her verified Bill of Particulars, by her attorneys, ***SHAEVITZ & SHAEVITZ, ESQS.***, in response to defendant **CIRCUIT CITY STORES, INC.**'s demands, upon information and belief, respectfully allege:

1. The incident occurred on December 28, 2006, at approximately 3:00 P.M.

2. The accident occurred upon the premises known to the public as "CIRCUIT CITY" located at 9605 Queens Boulevard, Rego Park, in the County of Queens, City and State of New York.

3. The defendant, its agents, servants and/or employees, were negligent as follows:

In causing, allowing, suffering and/or permitting the plaintiff to be struck, assaulted, battered, knocked to the ground as to cause injury to the plaintiff herein; in failing to employ and/or employed insufficient number of security personnel and /security guards as a reasonable precautionary measure to prevent and/or reduce the likelihood of an assault occurring within it's premises ; in failing to take any measures in preventing an assault on the herein plaintiff; in negligently hiring and negligently keeping in their employ members of their security personnel and

security guards; in failing to keep and maintain said premises and business in a peaceful and safe condition; in failing to properly train their employees and/or security guards, to permit actions and performances in a safe, proper manner so the aforesaid premises would not be dangerous to customers and/or shoppers; in failing to properly instruct the security guards in their performance of the duties required and demanded of them; in hiring untrained security guards; in knowingly hiring, employing and retaining in its employ inexperienced, incompetent, careless and reckless employees; in creating and maintaining a menace, hazard, nuisance and trap thereat; in causing a life threatening condition; in creating and maintaining a menace, hazard, nuisance and trap thereat; in negligently training and supervising; failing to properly comply with the rules, regulations, ordinances and statutes of the City and State of New York all in violation of the laws, statutes, ordinances and regulations made and provided for the safe and proper operation, ownership, maintenance and control of said premises. Plaintiffs further rely upon the doctrine of Res Ipsa Loquitur.

4. Plaintiff alleges that defendant violated all applicable statutes, rules, regulations and ordinances and will ask the trial Court to take judicial notice of same.

5. As a result of the defendants' negligence, plaintiff ANNA THOMAS, was caused to sustain the following injuries and/or traumatic aggravation of dormant pre-existing conditions:

- ◆Right distal radial fracture requiring closed reduction;
- ◆Tear of the right radial ulnar ligament and scaploid lunate ligament;
- ◆Tear of the triangular fibro-cartilage, right wrist;
- ◆Joint effusion, flexion tenosynovitis and deformity of the scaphoid, right wrist;
- ◆Tenderness and weakness of the right wrist;
- ◆Restricted range of motion of the right wrist;

◆Right shoulder impingement;

◆Restricted range of motion of the right shoulder;

◆Multiple sprains, strains, swelling, bruises, contusions, pains; limitations of ranges of motion; nerve fiber, sympathetic nerves, muscle and tendon damage; with resultant emotional stress, acute mental anxiety, inability to perform everyday functions, loss of normal pursuits and pleasures of life, and all sequelae resulting therefrom.

All of the above injuries are permanent with the exception of those of a superficial nature which have already resolved.

6. a) Plaintiff was confined to bed immediately following this accident for approximately one (1) week and intermittently thereafter.

b) Plaintiff was confined to the house immediately following this accident for approximately one (1) month and intermittently thereafter.

c) Plaintiff was confined to Elmhurst Hospital, 79-01 Broadway, Elmhurst, New York 11373 on 12/28/06. Then plaintiff was also confined to St. Lukes Roosevelt Hospital, 1111 Amsterdam Avenue, New York, New York 10025 on 12/29/06.

7. a) Plaintiff was born on 05/26/37 and her social security number is 053-46-3979.

b) Not applicable.

c) Not applicable.

d) Not applicable

e) Not applicable

f) Not applicable

8. Special damages are claimed in the following amounts:

a)	Hospital expenses (amount approximate, not all bills having been Rendered to date.)	-	$6,000.00
b)	X-rays	-	Included in hospital services
c)	Physicians' services, (amount approximate, not all bills having been Rendered to date.)	-	$4,965.00
d)	Nursing services' or other medical expenses	-	Included in hospital services
e)	Medical supplies	-	Included in hospital services
f)	Loss of earnings	-	Not applicable
g)	Amount of Nature	-	Not applicable.

9. Upon information and belief, plaintiff hospital and medical bills were paid by Sedgwick Claims Services, P.O. Box 171816, Memphis, TN 38187, claim no.: A767046480.

The amount of said reimbursements will be provided under separate cover.

10. Plaintiff resides at 99-10 60th Avenue, Apt. 5J, Corona, New York 11368.

Plaintiffs reserve the right to further respond to this bill of particulars as per the CPLR.

Dated: Jamaica, New York
November 1, 2007

Yours, etc.,

SHAEVITZ & SHAEVITZ, ESQS.
Attorneys for Plaintiff(s)
148-55 Hillside Avenue
Jamaica, New York 11435
(718) 291-3400

To: ***RENDE, RYAN & DOWNES, LLP***
Attorneys for Defendant(s)
CIRCUIT CITY STORES, INC.
202 Mamaroneck Avenue
White Plains, New York 10601
(914) 681-0444
File No.: S-125-CW

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

----------X

ANNA THOMAS,

Plaintiff(s),

RESPONSE TO NOTICE FOR DISCOVERY & INSPECTION

-against-

CIRCUIT CITY STORES, INC., and "JOHN DOES", said named being fictitious and is intended to represent the unknown employees of the defendant.

Defendant(s).

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Plaintiffs, by and through their attorneys, **SHAEVITZ & SHAEVITZ, ESQS.,** respectfully respond to defendants' Discovery Demands as follows:

1. Plaintiff is unaware of any witnesses to the accident in question other than defendants' employees who caused this accident, and helped plaintiff after said accident. The identities of their employees is more particularly within the knowledge of the defendants herein.

2. Plaintiff is not in possession of any communications with the defendants.

3. Plaintiff is not in possession of any photographs.

4. Plaintiff is not in possession of any reports prepared in the regular course of business.

5. Plaintiff is not in possession of any notes, records or diagrams prepared from information provided by the defendants.

6. Plaintiff has not retained the services of any expert witnesses at this point other than the plaintiff's medical providers, for whom reports and/or authorizations have been exchanged.

7. Student is not applicable.

8. Collateral source information will be provided under separate cover.

9. Social Security benefits are not applicable.

10. Annexed hereto are copies of all medical records in the plaintiff's possession in reference to this occurrence, along with duly executed authorizations for the release of all hospital records, physicians records, x-ray films, MRI's, diagnostic tests, technicians reports, therapy records and prescriptions.

11. Upon information and belief, plaintiff hospital and medical bills were paid by Sedgwick Claims Services, P.O. Box 171816, Memphis, TN 38187, claim no.: A767046480.

12. The only parties appearing in the within action to date are the undersigned, representing the plaintiff and ***Rende, Ryan & Downes, LLP,*** representing the defendant CIRCUIT CITY STORES, INC.

13. The index number 20767/07 was purchased from Supreme Court, Queens County on August 20, 2006.

Dated: Jamaica, New York
November 1, 2007

Yours, etc.,

SHAEVITZ & SHAEVITZ, ESQS.
Attorneys for Plaintiff(s)
148-55 Hillside Avenue
Jamaica, New York 11435
(718) 291-3400

To: ***RENDE, RYAN & DOWNES, LLP***
Attorneys for Defendant(s)
CIRCUIT CITY STORES, INC.
202 Mamaroneck Avenue
White Plains, New York 10601
(914) 681-0444
File No.: S-125-CW

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

----------X

ANNA THOMAS,

Plaintiff(s),

-against-

CIRCUIT CITY STORES, INC., and "JOHN DOES", said named being fictitious and is intended to represent the unknown employees of the defendant.

Defendant(s).

----------X

RESPONSE TO DEMAND FOR EXPERT WITNESS

Plaintiff, by and through his attorneys, **SHAEVITZ & SHAEVITZ, ESQS.,** respectfully respond to defendants' Demand for Expert Witnesses as follows:

Plaintiff intends to rely upon the economic, medical and/or chiropractic and/or therapy and/or radiological records, films and testimony of the following economists, physicians, chiropractors, therapists, radiologists, and other medical providers whose names, reports, records and/or authorizations have previously been exchanged with counsel and/or carriers, and/or are exchanged herein.

The substance of the facts and opinions of such doctors are set forth in the medical records and/or reports previously provided and are incorporated by reference herein.

The basis for such doctors conclusions are their examinations of the plaintiff in addition to their review of medical and hospital records in this proceeding.

Plaintiff reserves the right to further respond to this demand prior to the time of trial.

Dated: Jamaica, New York
November 1, 2007

Yours, etc.,

SHAEVITZ & SHAEVITZ, ESQS.
Attorneys for Plaintiff(s)
148-55 Hillside Avenue
Jamaica, New York 11435
(718) 291-3400

To: ***RENDE, RYAN & DOWNES, LLP***
Attorneys for Defendant(s)
CIRCUIT CITY STORES, INC.
202 Mamaroneck Avenue
White Plains, New York 10601
(914) 681-0444
File No.: S-125-CW